Joint Interim Committee on Missouri Health Care Systems

Report and Recommendations

February, 1988

REPORT AND RECOMMENDATIONS

JOINT INTERIM COMMITTEE

ON MISSOURI HEALTH CARE SYSTEMS

FEBRUARY, 1988

SUMMARY: In 1987, the Joint Interim Committee on Missouri Health Care Systems conducted a study of the state's health care service delivery mechanisms. The interim study served to promote the legislature's discussion of accessible health care services, to bring people outside the legislature into the policy process and to establish a consensus on solutions to service delivery problems. In addition, the study confirmed earlier findings and revealed the presence of growing pressures. The committee recommends that the General Assembly take steps to 1) delineate health policy responsibilities; 2) strengthen community resources; 3) improve Medicaid services; 4) establish a publicly supported health benefit plan; 5) encourage availability of private insurance plans; and 6) collect and use health care cost data.

TO THE MEMBERS OF THE EIGHTY-FOURTH GENERAL ASSEMBLY:

In accordance with responsibilities set out in House Committee Substitute for Senate Concurrent Resolution No. 6 enacted by the 84th General Assembly, First Regular Session, 1987, the duly appointed members of the Joint Interim Committee on Missouri Health Care Systems respectfully submit their report and recommendations.

Senator Edwin L. Dirck
Chairman, District 24

Representative Jerry W. Burch
Vice Chairman, District 124

Senator J.B. "Jet" Banks
District 5

Representative Gail L. Chatfield
District 69

Senator David Doctorian
District 28

Representative Gene Lang
District 120

Senator Henry A. Panethiere
District 11

Representative Carole Roper-Park
District 52

Senator Truman E. Wilson
District 34

Representative Beth Wheeler
District 3

COMMITTEE MEMBERS

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Pro Tempore of the Senate

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Senator Edwin L. Dirck District 24	W. D. Dandridge, Jr., M.D. Joplin, Missouri
Senator David Doctorian District 28	Dorothy Giardina, Administrator West County Care Center Ballwin, Missouri
Senator Henry A. Panethiere District 11	Max Poll, Chief Executive Officer Barnes Hospital St. Louis, Missouri
Senator Truman E. Wilson District 34	Dian Sharma Commissioner of Health St. Louis, Missouri

Members Appointed by the
Speaker of the House of Representatives

Voting	Non-voting
Rep. Jerry W. Burch District 124	Keith Ayres, Executive Director Mid-America Coalition on Health Care Kansas City, Missouri
Rep. Gail L. Chatfield District 69	Mark Garges, Administrator Hamilton Hill Crest Manor Hamilton, Missouri
Rep. Gene Lang District 120	Meyer L. Goldman Kansas City, Missouri
Rep. Carole Roper-Park District 52	Lowell C. Kruse, Chief Executive Officer Heartland Health Systems, Inc. St. Joseph, Missouri
Rep. Beth Wheeler District 3	Fred C. Tinning, Ph.D., President Kirksville College of Osteopathic Medicine Kirksville, Missouri

Non-Voting State Agency Members

Donald L. Gann
Assistant Commissioner for Vocational Rehabilitation
Department of Elementary and Secondary Education
Jefferson City, Missouri

Robert Harmon, M.D., M.P.H.
Director
Department of Health
Jefferson City, Missouri

Raymond W. McCann, Director of Personnel
Division of Employment Security
Department of Labor and Industrial Relations
Jefferson City, Missouri

Jim Moody*
Executive Deputy Director
Department of Social Services
Jefferson City, Missouri

C. Keith Schafer, Ed.D.
Director
Department of Mental Health
Jefferson City, Missouri

Susan Vaughan, Director
Missouri Head Injury Advisory Council
Office of Administration
Jefferson City, Missouri

*(Donna Checkett, DOSS Legislative Coordinator, filled Jim Moody's unexpired term when he left the position that qualified him for representation.)

Committee Staff

Senate	House
Jackie Carter Secretary to Senator Dirck	Claudia Walz Secretary to Rep. Burch
Toni Messina Senate Research Analyst	Daniel Landon House Research Analyst
Mary Lou Scott Diane Skaggs Recording and Transcribing	

THE JOINT COMMITTEE ON MISSOURI HEALTH CARE SYSTEMS

State legislators formed the Joint Committee on Missouri Health Care Systems with the passage of House Committee Substitute for Senate Concurrent Resolution No. 6 during the 84th General Assembly, First Regular Session, 1987. The resolution established the premise that a significant number of Missourians appear to lack adequate health care services because of financial need or because their specific medical conditions prevent them from obtaining health insurance coverage.

To address this problem, the resolution directed the committee to conduct a thorough study of the state's health services system for financially and medically needy persons, including an examination of the following topics:

(1) Better coordination of existing state health care programs;

(2) The structure of the existing health services system;

(3) The provision and availability of health services across the state;

(4) The level of funding of health services and how funding is directed;

(5) The state's use of federally funded health services; and

(6) Incentives and disincentives for providers to participate in current health programs providing care to the financially and medically needy.

The resolution further required the committee to report its recommendations to the 84th General Assembly.

Chaired by Senator Edwin L. Dirck and Representative Jerry Burch, the joint committee was composed of five senators, five state representatives, and six officials representing state agencies and services. The committee also included five members of the general public appointed by the President Pro Tempore of the Senate and five more named by the Speaker of the House of Representatives. All were chosen for their knowledge of issues and programs most likely to affect delivery of health services. Legislators, for example, contributed their years of experience with state appropriations, public health and welfare, insurance matters and employment practices. Agency officials complemented this experience with their knowledge of rehabilitative, referral, social and health service delivery. Public members reflected the interests of purchasers and providers of health services.

The interim committee heard public testimony in seven locations during September and October, 1987: Springfield, Kansas

City, St. Louis, Cape Girardeau, Columbia, Kirksville and Jefferson City. Of the 92 witnesses who testified before the committee, almost half represented the interests of public and private health service providers. Advocates for improved health services and under-insured persons themselves made up 21 percent and 14 percent of the witnesses, respectively. Twelve percent of the witnesses provided more objective, "expert" testimony, and five percent represented the interests of employers.

From this testimony, committee members identified a number of widespread concerns and problems which can be addressed through legislative and administrative actions. The committee, therefore, hopes that the General Assembly will give serious consideration to the recommendations contained in this report.

ORIGINS OF THE STUDY

Before proceeding to the recommendations proposed in this report, the members of the General Assembly are respectfully asked to consider the context in which the joint interim committee's study took place. An understanding of events leading up to the passage of HCS/SCR 6 reveals the nature of the committee's assignment.

In 1985, the General Assembly appropriated $150,000 for a professional examination of financial accessibility to health care services in Missouri. When findings were published in 1986, many were surprised to learn that almost one out of every five of the state's citizens had either inadequate health insurance coverage or, even worse, no coverage at all. A House panel convened to review the topic of indigent health during the 1986 interim.

Chaired by Rep. Jerry Burch, the House interim committee travelled the state to verify, through public testimony, the sobering findings of the study. The committee also issued recommendations for solving some of the problems associated with medical indigency. These recommendations were based on two premises:

1. Health care for those not covered by private or governmental insurance is an express social responsibility; and

2. Legislative solutions of a limited scope should be enacted only in conjunction with a comprehensive plan to provide health insurance to all who need it.

House Bill 146, considered during the 1987 legislative session, was the comprehensive social statement that grew out of the House committee's work. Sponsored by Rep. Burch, the Missouri Medial Assistance Insurance Trust, or "MedAssist", proposal established a mechanism for insuring persons with incomes too high to qualify for public assistance but too low to afford health insurance premiums or out-of-pocket health expenses. House Bill 146 required actuarial and administrative soundness. Funds would be generated by a new, earmarked one-cent sales tax. House members, already familiar with an earlier indigent care measure proposed to them in 1986, debated the bill at length but finally passed HCS/HB 146 late in the legislative session.

Although the House of Representatives focused publicly on the indigent health care issue for at least two years, the Senate had not engaged in similar discussion. Thus, the 1987 legislative session provided the members of the Senate with their first opportunity to consider a comprehensive health assistance plan (HB 1337, the 1986 proposal, did not reach the Senate). The Senate Committee on Aging an Mental Health, to which HCS/HB 146 was

referred, passed the bill without a funding mechanism. After a short period of floor debate, HCS/HB 146 died June 15, 1987, on the Senate informal calendar.

HCS/SCR 6 reflects a desire to continue, on a joint legislative basis, discussion of the problems of Missourians without access to adequate health care. Sponsored by Senator Edwin L. Dirck, the resolution was not an attempt to recreate the work of the 1986 House interim committee. Instead, the resolution created an opportunity to review all components of Missouri's health care delivery system; to officially involve those outside the legislature in the policy process; and to forge a consensus leading toward acceptable solutions.

The report issued by the House Interim Committee on Indigent Health Care in January, 1987, succinctly presents the causes of the indigent health care problem and briefly summarizes testimony provided by groups interested in the issue. In addition, the study commissioned by the General Assembly in 1985 describes in detail factors affecting Missouri's uninsured population. Testimony gathered by the Joint Interim Committee on Missouri Health Care Systems tends to confirm information contained in these documents. Rather than restate what already is known, members of the General Assembly are referred to the House report (attached as Appendix A of this report) and to the study (available from the House and Senate research offices) for background material.

COMMITTEE RECOMMENDATIONS

Despite similarities in testimony presented to the two interim committees in 1986 and 1987, the Joint Interim Committee on Missouri Health Care Systems cannot simply dismiss what it learned in its own public hearings. Perhaps the most valuable, though disappointing, knowledge committee members gained was that the problems described in 1986 have worsened and are likely to be even more pronounced in years to come.

The overall cost of obtaining health care can be expected to increase each year. Increases are fueled by the cost of labor, liability insurance, administrative overhead, advancing technology and utilization patterns. As additional costs are absorbed and shifted in a continuous cycle, health providers compete for market shares, third party payers warn against unnecessary use of health care services and consumers face bitter choices. Those who are fortunate enough to have health insurance coverage pay more in premiums, deductibles and co-payments to help support the service delivery system. Those who lose access to or who cannot obtain health insurance coverage fall out of the system.

The health care needs of Missourians will multiply in volume and complexity. Natural increases in population will account for a relatively limited portion of new service demands. The service delivery system also must accommodate persons with acute health care needs: seriously ill infants, persons suffering traumatic injuries and the growing number of individuals who will reclaim their lives with the use of transplanted organs. The system must prepare to define and provide long-term care services for the disabled and elderly and for persons of any age who suffer from Alzheimer's disease. The system must confront the staggering threat of AIDS in a humane and reasonable way.

There is ample evidence that growing costs and demands are exerting tremendous pressures on Missouri's health care system. It is painfully apparent that the goal of providing universally adequate basic health care is not only a social issue, but an economic issue as well. Members of the joint interim committee observed among themselves and on the part of those who offered public testimony an agreement upon the need for change in the service delivery system but a reluctance to assign ultimate responsibility for the change.

In preparing its recommendations for improving Missouri's health care system, the committee faced the challenge of assigning responsibility and finds, unquestionably, that it must be shared by all who have an interest in accessible health care. Solutions lie, the committee believes, in articulation of a common goal, in mobilization of public and private resources and in gaining greater knowledge of Missouri's health care environment.

Articulation of a Common Goal

Recommendation 1: To improve funding, coordination and administration of public health services, there should be a clear delineation of areas of responsibility for determining health care policy.

The committee recognizes the difficulty of defining clear roles for each entity involved in public health policy-making. As funding sources emerge and decline, as administrative authority shifts from one level of government to another and as needs arise which require cooperative resolution from a variety of entities, accountability suffers. Nevertheless, it is necessary to develop a functional policy-making mechanism that avoids both comprehensive authority on the part of a single agency and fragmented, uninformed decision-making by all agencies.

The committee finds a need to identify and agree upon a collective health service delivery mission for Missouri. The committee finds also a need to delineate policy-making responsibilities vertically, among levels of government, and laterally, across any given level of government. This task would involve consideration of both the actual and the preferred areas of responsibility assigned to the state's Department of Social Services, Department of Health and Department of Mental Health. The objective is to arrive at an appropriate blend of interests that results in equitable, reasonable health policy decisions.

Mobilization of Public and Private Resources

Recommendation 2: Legislative and administrative steps should be taken to enhance health service delivery at the community level.

The committee recognizes that strong community health networks are good medicine. When supplied with adequate financial and professional resources, communities are capable of delivering health services when and where they are needed. Tough financial pressures in recent years, however, have turned local public health activities into desperate struggles to balance available resources against the most crucial needs.

To strengthen and support community health networks, the committee recommends six steps.

a. Case management systems should be established within all local health units to assure continuity of care and assistance for persons who cannot independently obtain adequate health care.

b. Local health units should be granted increased flexibility to establish nominal charges, on a sliding scale based on ability to pay, for certain services. This might encourage those too proud to accept "welfare" to seek at least basic health care and referral

services. Because of the state's over-riding interest in safeguarding public health and safety, however, charges should not be imposed for immunization or communicable disease services.

c. Programs that allocate resources to community hospitals serving Missouri's medically needy population should be sufficiently funded. Money appropriated to the Department of Health for public hospital subsidies, for Missouri Crippled Children's Services and for medical services aimed at preventing mental retardation should not be transferred to the Department of Social Services and used as the state matching requirement for federal Medicaid dollars. Instead, those funds should be maintained as resources outside of and in addition to appropriations for the state's Medicaid program.

d. Current state laws should be changed to promote placement of primary care practitioners in areas of defined need. Missouri's existing medical student loan program makes up to $6,000 per year available to individual students earning degrees in allopathic or osteopathic medicine. Loan payments may be deferred until residency programs are completed, or a portion of the loan may be forgiven for each year a person operates a general or family practice in an area with defined physician shortages.

Witnesses told committee members, however, about several problems associated with the program: there are too few loans; loans are too small; there is not a good history of loan repayment; and the program has not been successful in stabilizing physician commitments to under-served areas. Therefore, the committee recommends statutory changes that would bring in new federal funds, available on a 75 percent federal, 25 percent state matching basis, for the purpose of forgiving school loans assumed by medical students agreeing to establish primary care practices in specific locations.

e. All maternal and child health care services should be better integrated and coordinated. Legislation enacted in 1987 provides new authority for the Department of Health and the Department of Social Services to cooperatively serve pregnant women and young children in local public health settings using Medicaid dollars. The agencies should take all necessary steps to assure that persons receive immediate, thorough and caring assistance.

f. The Department of Health should inform physicians, especially those in rural areas, of new opportunities to serve Missouri's medically needy population. Legislation enacted in 1987 offers liability protection through the State Legal Expense Fund for physicians who provide maternal and child health care services through contracts with local public health units. Immediate and continuing action is needed to recruit practitioners who can bolster community health networks.

<u>Recommendation 3: Missouri should take advantage of all available authority to enhance,expand and improve services available through its Medicaid program.</u>

Although Congress has provided many options for meeting health care needs with federal Medicaid dollars, Missouri has been slow to capitalize on these opportunities. The committee recognizes that new state funds must be used to generate new federal matching funds, but the prospect of obtaining $1.50 for every Missouri dollar put forward is attractive. This financial return is especially important for state agencies that now use only General Revenue to purchase health care for the people they serve. To derive all possible benefit from federal authority, the committee recommends four steps.

a. The number of persons eligible for Medicaid services should be increased by:

- raising AFDC income-eligibility standards and making more persons categorically eligible for services;

- automatically covering pesons who receive Supplemental Security Income (SSI) benefits rather than applying current, more restrictive eligibility standards;

- establishing benefits for medically needy persons whose incomes do not exceed 133 perent of the state's AFDC payment standard;

- expanding coverage for aged, blind and disabled persons whose incomes fall between SSI limits and one hundred percent of the federal poverty level;

- relaxing state asset eligibility requirements in general and possibly eliminating asset tests altogether for pregnant women and children who meet income tests.

b. The committee also recommends expanding the number of services covered by Missouri's Medicaid program. "Waivers" should be obtained so that some services now reimbursed only in nursing homes and hospitals can be reimbursed in less costly community settings. Primary care and other services which can help prevent or avoid institutionalization should be covered. Further study is needed to review the growth of Medicaid nursing home payments and to identify health services now funded by General Revenue which could be funded with federal-state Medicaid dollars.

c. In addition to advocating more services for an expanded group of eligibles, the committee recommends encouraging Medicaid provider participation by increasing rates of reimbursement. Outpatient service rates and physician reimbursement should be liberalized. Increased inpatient service rates should be available, without jeopardizing the state subsidy for public

hospitals, for institutions that serve disproportionate numbers of low-income persons.

d. As a final component to improvements in Missouri's Medicaid program, the committee recommends a review of administrative functions affecting services delivered or purchased by state agencies using Medicaid dollars. Consideration should be given to identifying appropriate administrative any policy responsibilities, fiscal controls and cooperative mechanisms for rate setting.

Recommendation 4: The General Assembly should establish an actuarially sound health benefit plan for persons who have the least access to health insurance coverage.

The joint interim committee recommends quick enactment of legislation that addresses the needs of two primary groups: employed or unemployed persons whose incomes permit neither eligibility for Medicaid nor their ability to purchase private insurance, and individuals with medical conditions considered too great a risk for commercial insurance coverage even where there is an ability to pay the premium. Coverage for low-income and high-risk groups should be mandatory. Optional coverage should be available for persons with catastrophic health expenses and long-term care needs if they can pay premiums that reflect the cost of insurance.

The committee visualizes that the plan will be operated in a business-like manner by a board of directors possessing appropriate power and authority. Board powers would include the ability to design the benefit plan, set conditions and rates for provider reimbursement, develop administrative procedures, review service utilization, collect data, establish cost containment mechanisms and promulgate rules and regulations. Claims payment and processing functions should be assigned to an administering insurer.

During their study, committee members became aware that much of the loss of individual health insurance coverage reflects changes in the nation's economy. In Missouri and in other states, jobs in manufacturing industries are being replaced by jobs in the service sector. Between January-March, 1987, for example, the number of manufacturing jobs in Missouri decreased from 415,328 to 415,250. Jobs in the non-manufacturing sector, in contrast,

increased from 1,334,963 to 1,354,992 during that same period.*

This trend typically indicates the existence of fewer labor agreements providing insurance benefits, greater dependence on part-time workers and lower per capita earnings. Between January-March, 1987, a person employed in a non-manufacturing job, on the average, earned 70 percent less than his counterpart in the manufacturing sector.* Under these conditions, it seems likely that loss of individual insurance coverage is significantly affected by plant closings, by conscious employer choices not to provide insurance and by conscious employee choices not to purchase coverage.

Thus, the committee recommends that legislative solutions include efforts to promote equitable access to health insurance coverage by involving both employers and employees. A minimum health benefit plan should be defined by law. Employers not meeting minimum standards should be assessed a potion of their payroll and the money deposited in a special fund created for the state-sponsored health benefit plan. A portion of the wages earned by persons who work for these employers also should be deposited to the fund. Supplemented by premiums, co-payments, deductibles, and interest income, the fund should provide all resources for paying the costs of benefits and administration.

Most importantly, the health benefit plan must be able to deliver what it promises. Enabling legislation must require strict stewardship by the board of directors. Benefits and premiums should be developed in accordance with actuarial data. Benefit payments should be based on the cost of health care services. The board should have the ability to adjust premiums and benefits to maintain the plan's financial soundness. The plan should not place an additional burden on the state's General Revenue fund.

Recommendation 5: Missouri should take steps to promote privately financed health care protection for the uninsured.

While the committee feels strongly about public guarantees for accessible health care, members are equally concerned about improving the availability of commercial insurance coverage. Each dollar spent for private health care protection reduces the need to generate public resources. The state may be able to encourage private protection by informing employers and employees about the types of benefit plans which can be purchased. In any case, the committee's ultimate goal is not to create new public mechanisms but to improve access in the existing health care delivery system.

*ES-202 Report of Employment, Wages and Contributions, Missouri Division of Employment Security.

Knowledge of Missouri's Health Care Environment

Recommendation 6: Missouri should develop informational tools to encourage more prudent purchases by public and private buyers of health care services.

The committee is impressed with steps taken by coalitions of health care service purchasers to develop objective data. This information is useful not only in charting expenditure trends but also in making health care purchasing decisions. As a major purchaser of health care through public assistance programs and through its employee benefit plans, the State of Missouri is obligated to serve the public interest with prudent actions. To that end, the committee recommends establishing uniform and consistent data disclosure requirements for health care providers.

APPENDIX A: Final Report of the House Interim Committee on Indigent Health Care

INTERIM COMMITTEE ON INDIGENT HEALTH CARE

FINAL INTERIM REPORT

January, 1987

Representative Jerry Burch, Chairman

Representative Sheila Lumpe, Vice-Chairman

Rep. Mark Youngdahl

Rep. George Hoblitzelle

Rep. Joe Driskill

Rep. Derek Holland

Rep. Gail Chatfield

Rep. Carole Roper Park

Rep. Bob Holden

Rep. Gene Lang

Rep Ken Jacob

Rep. Walter Peterson

Rep. Russell Brockfeld

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INTRODUCTION

The Missouri House of Representatives' interim committee on indigent health care was appointed by Speaker of the House Bob F. Griffin to accomplish two objectives. First, the committee was to study the effect of uncompensated health care costs on Missouri's health care delivery system. Second, it was to analyze policy options to reduce the adverse effects of uncompensated health care and develop appropriate legislative proposals.

The committee used as a starting point for its deliberations the "Missouri Indigent Health Care Study." The General Assembly, recognizing the need for specific information regarding the extent to which Missourians are unable to pay for health care, appropriated funds in 1985 for a comprehensive study of the problem. The study was conducted by Health Systems Research, Inc., a consulting firm specializing in health care finance policy.

The study speaks for itself. We will not delve into the details of the three hundred fifty page document other than to recite its conclusion that 1,000,000 Missourians, 20% of the state's population, have either no health insurance or substandard insurance coverage. 617,000 were found to have no health insurance coverage at least once during a year, 300,000 low-income, nonelderly persons to have inadequate private insurance, 55,000 low-income elderly persons to lack necessary Medicare supplement insurance, and 36,000 people, regardless of income, to incur annual medical expenses in excess of ten percent of their household income.

In its hearings around the state, the committee sought to determine if the numerical findings of the study were validated by testimony from those familiar with the issue -- health care providers, consumers, Medicaid recipients, victims of catastrophic illnesses, social service advocacy groups, businesses concerned with the cost of health care insurance, state agency representatives, etc. Many witnesses spoke directly to the findings of the study. Others confirmed its conclusions with anecdotal evidence.

The committee also sought and received testimony as to the implications of the report for state policy. Witnesses made various legislative proposals and discussed bills previously considered by the General Assembly.

CAUSES OF THE INDIGENT CARE PROBLEM

Historically, much of the cost of uncompensated health care has been dealt with by providers increasing charges to paying customers to cover the cost of such care. This process is known as cost-shifting. Also, many hospitals participated in the Hill-Burton program, a postwar federal program which required hospitals receiving federal subsidies for capital expansion to provide a certain amount of charity care.

The question arises, then, as to why those mechanisms are becoming less viable. Why has uncompensated care become an increasingly pressing problem in recent years? Most of the important reasons can be categorized under two responses -- an increasing lack of adequate health insurance coverage and changes in the health care marketplace.

I. An increasing lack of adequate insurance coverage

Changing employment patterns. Health insurance is most commonly provided as a fringe benefit of employment. However, the U.S. economy is changing from an emphasis on manufacturing and production to service sector jobs. As manufacturing jobs disappear, displaced workers are finding new jobs which do not provide health insurance, jobs such as fast-food workers or discount store clerks. Many such jobs do not pay well enough to allow the purchase of individual health coverage policies.

A poor agricultural economy. Falling prices for agricultural products and plummeting land values have caused depressed economic conditions across much of rural Missouri. As farms falter so do economic conditions in rural towns, leaving many without jobs or sufficient income to buy private health insurance coverage.

Costly medical treatment capabilities. Medical practitioners are constantly improving their ability to save patients with conditions that would have been fatal 40 or 50 years ago. Unfortunately, advanced medical technology is expensive, beyond the reach of all but the wealthiest individuals unless health insurance coverage is available. The uninsured are faced with a choice between not receiving care and accepting charity care, a dilemma voiced by several witnesses before the committee.

Ineligibility for coverage. Patients with serious ailments often find that health insurance becomes unavailable or prohibitively expensive. Without adequate coverage, even minor health care can be a heavy financial burden. As health care costs have risen rapidly during the past several decades, health insurance has become a necessity.

Restricted governmental expenditures for health care. During the last decade, reimbursements for Medicare and Medicaid patients have been limited or reduced to control expenditures. As health care costs have risen, reimbursements have not kept pace. The difference between costs and reimbursements is known as contractual allowances.

Governmental funding for public and teaching hospitals, an important component of health care for the indigent, is also being reduced or limited in growth because of restrained governmental spending.

II. Changing Health Care Marketplace

As various changes in the health care marketplace limit the ability of health care providers to pass on the costs of uncompensated care, the impact of such care upon their financial solvency increases.

Changes in governmental reimbursement procedures. In recent years, both Medicare and Medicaid have been altered so as to minimize cost-shifting to the patients they insure. Both programs now reimburse based not on retrospective charges but prospective average costs for a particular diagnosis. As a significant number of patients have health insurance through Medicare or Medicaid, these restrictions on cost-shifting force health care providers to shift costs to a smaller number of patients or to absorb those costs.

Health discounts for employers. Employers, like governments, have become increasingly sensitive to expenditures for health care made on behalf of their employees. The increased use of health insurance arrangements such as health maintenance organizations and preferred provider agreements has allowed businesses to limit the amount of cost-shifting to the patients they insure. As the health care marketplace grows more competitive among providers, the use of capitated payment systems such as HMO's and PPA's will become more common, further restricting the number of patients to whom health care providers can shift costs.

Liability insurance increases. Liability insurance premiums for health care providers have increased dramatically during the latest medical malpractice insurance "crisis." This increase has caused the cost of providing health care to each patient to rise. Thus, providing care to indigent patients is more costly to providers than in the past.

The use of Medicaid to fund long term care. The Medicaid program is increasingly used to fund payments for long-term custodial nursing home care for the indigent elderly. The percentage of Medicaid expenditures used for nursing home care is high and likely to increase as the population ages. The use of Medicaid as a payment source for long-term care benefits the indigent

elderly, but reduces Medicaid resources for noninstitutionalized patients and the providers who treat them.

Expiration of Hill-Burton obligations. As mentioned previously, hospitals which took advantage of a postwar federal program to subsidize hospital expansion are required to provide a certain amount of charity care to indigent patients. However, a hospital accepting funds need only provide obligatory charity care for twenty years after the capital expansion is completed. These Hill-Burton obligations are now expiring for many hospitals and all will have expired by 1994.

SOLUTIONS

I. Premises

The committee bases its findings and recommendations on two premises. The first is that health care for those not covered by private or governmental insurance is an express social responsibility. Historically, health care for the uninsured has been addressed largely by health care providers raising rates for paying customers to cover the cost of such uncompensated care. The cost, therefore, has been paid by those purchasing health care and the insurance plans which covered them. This cost is passed on to consumers through higher insurance premiums paid by both purchasers of individual policies and employer group plans. Increased costs to employers are passed on to consumers through higher product prices.

This system of access and payment is becoming less viable with the competitive marketplace restricting the ability to cost-shift. It is also less preferable in that the social expenditures for such care are not expressly recognized or managed. They take the form of hidden "indirect costs."

These costs should be formalized, monitored, and controlled as express social costs. Hence, some type of governmental management is necessary to ensure that access to health care is fair and based on uniform criteria and that the cost of such care is managed efficiently and explicitly.

The second premise of the committee is that limited legislative proposals should only be enacted in conjunction with a comprehensive plan to provide insurance to all who need it. A variety of proposals have been advanced in response to current problems with uncompensated care. Each of these proposals would doubtless be effective in addressing a portion of the problem. For example, the Health Systems Research report makes a number of recommendations, including the establishment of "medically needy" program to cover persons not currently eligible for Medicaid. A medically needy program would provide Medicaid coverage for pregnant women, children, and certain groups of aged or disabled persons.

The enactment of piecemeal solutions would expand coverage for certain groups or make certain programs more efficient, but would not provide a solution comprehensive enough to benefit the 1,000,000 Missourians identified by the report to be in need of assistance. The individual recommendations should be implemented only within the context of an overall plan to ensure adequate insurance coverage for all those in need.

II. Recommendations

Recommendation 1: The General Assembly should adopt legislation to establish a state "MedAssist" trust fund to provide health insurance for those unable to qualify for existing governmental health insurance programs or to acquire adequate private health insurance coverage. Funding should be selected by the General Assembly from one or a combination of the following revenue sources: increases in the income, sales, cigarette, or insurance premium taxes; assessments on health care providers or employers; or earmarking of a portion of the projected tax revenue "windfall" caused by federal income tax revisions. The funding source should be earmarked and subject to referendum.

20% of the state's population lacks adequate health insurance or has substandard coverage, according to the Health Systems Research report. The state must provide these Missourians with access to adequate health insurance based on their ability to pay.

Various states have considered legislative proposals to help the uninsured. Hawaii, armed with a federal waiver which allows it to regulate self-insured groups, mandates that all employers offer health insurance coverage. One state has considered providing uninsured persons with vouchers for the purchase of approved private insurance policies. Missouri has also considered a proposal to make health insurance available to the uninsured -- House Bill 1337 of the 1986 legislative session.

The committee supports some of the provisions of HB 1337, as follows:

1. Health insurance should be made available to those without adequate health insurance through a program funded by new revenues and by premiums based on ability to pay. A "MedAssist" program similar in scope to that proposed in HB 1337 could not be supported by existing revenues without crippling other essential state services.

2. Coverage should be extended to the groups identified in the Health Systems Research report: those not covered by governmental insurance programs who cannot afford adequate health insurance, experiencing a catastrophic illness which prevents them from acquiring insurance coverage, and senior citizens covered by Medicare who cannot afford necessary Medicare supplement insurance.

3. The program should be administered in keeping with accepted actuarial principles and procedures of private insurance companies. The program should be reviewed regularly by an independent health actuary to ensure fiscal soundness.

4. A program should be administered to include mandatory health care cost containment controls. Utilization review, preadmission review, second surgical opinions,and similar cost containment measures are being implemented in both governmental and private insurance programs. MedAssist administrators should use the procedures to ensure that payment is made only for health care which is necessary and efficient.

Any such legislative proposal to establish a MedAssist program should emphasize efficiency and public accountability by meeting the following conditions:

Accountability

1. The General Assembly should maintain authority over fiscal and regulatory administration of the program through its appropriation and regulatory review powers.

2. Program benefits provided to recipients must be defined so as not to exceed revenues. The state should not create an open-ended entitlement program; there must be a fixed cap on the revenue dedicated to a MedAssist program. Allowing program administrators to adjust benefits to conform with available revenue would give them the flexibility to tailor the best benefit plan without requiring statutory revision.

3. Proposed legislation should contain a sunset clause to mandate that a MedAssist program be discontinued unless reapproved by the General Assembly or, ideally, by referendum.

Efficiency

1. A MedAssist program should be administered by a board of directors rather than by a state agency. The board should be experienced in the development and management of insurance plans. Operating within statutory constraints, a board of directors make full use of its membership's experience in insurance, health care, and health care cost containment.

2. Claims processing for MedAssist benefits should be performed by a private company selected by competitive bid. This would minimize the need for governmental bureaucracy and capital facilities.

Recommendation 2: The General Assembly should consider expansion of Medicaid eligibility to maximize the use of federal funding.

In addressing the indigent care problem, the state should maximize its use of available federal funding. One means of doing this is to expand Medicaid eligibility to cover those who would otherwise be covered by a state-funded MedAssist program.

As sixty percent of Medicaid expenditures are paid by the federal government, state funds would be conserved. The federal government allows Medicaid coverage to be extended to certain groups such as pregnant women and children under the "medically needy" program. In addition, the MedAssist and Medicaid programs should be coordinated to ensure that care for those eligible for Medicaid coverage is not paid by the MedAssist program.

In developing a state insurance program to complement coverage through existing governmental programs such as Medicaid, the General Assembly should take precautions to prevent the development of a "three-tiered" health care system, with the best quality health care reserved for those with private or employer insurance, more restricted and inaccessible care for those covered by a state insurance plan as suggested here, and the most constrained and inaccessible care provided to Medicaid recipients.

Recommendation 3: The General Assembly should enact legislation authorizing a county-option sales tax to be used to fund local indigent care programs.

Should a MedAssist plan be rejected by either by the General Assembly or by referendum, local governments should be given the authority to submit proposals to county voters to fund local solutions.

Recommendation 4: The General Assembly should allow physicians providing care through local public health centers to participate in the state's Legal Expense Fund.

Skyrocketing medical malpractice premiums have reduced the availability of health care to the indigent or uninsured. For example, payments for obstetrical care and deliveries for Medicaid patients do not even cover the cost of the typical physician's liability cost for such care. Some physicians have stopped treating Medicaid patients, performing obstetrical services, or seeing patients in local public health clinics.

Allowing physicians to receive a partial reduction of liability for care provided in a public health center would increase the availability of care. Their participation in the State Legal Expense Fund would allow them to benefit from the same caps on liability as are provided state physicians when providing services on behalf of the state.

Recommendation 5: The General Assembly should adopt legislation to provide an insurance pool to provide coverage for those unable to qualify for insurance coverage.

If not incorporated as a part of a MedAssist program, the General Assembly should enact legislation to ensure that those who cannot qualify for private health insurance regardless of

their ability to pay are provided with access to insurance through an insurance risk pool.

Recommendation 6: The General Assembly should scrutinize eligibility criteria and benefits of existing programs which provide health care services to the uninsured or indigent to ensure administrative efficiency.

The "Missouri Indigent Health Care Study" by Health Systems Research, Inc. identifies and discusses programs which provide health care exclusively or partly to low-income persons. The information warrants attention. For example, the study describes the state's various programs to provide prenatal and perinatal care to low-income women. Differences in eligibility standards, benefit levels, and reimbursement procedures are sometimes striking. The General Assembly and the executive branch should work closely and diligently to ensure that programs are not duplicative and provide benefits equitably.

SCHEDULE OF COMMITTEE ACTIVITIES

The committee held the following hearings:

August 12-13	Capitol Building Jefferson City
September 16	Red Cross Building St. Louis
	St. Mary's Health Center St. Charles
October 1	Truman Medical Center Kansas City
October 2	Missouri Western State College St. Joseph
October 21	Jenny Lind Hall Springfield
November 12	Capitol Building Jefferson City
December 11	Capitol Building Jefferson City

WITNESSES

Hospitals

Truman Medical Center, Kansas City
St. Joseph's Health Center, St. Charles
Cox Medical Center, Springfield
St. Louis Regional Hospital, St. Louis
University Health Services, Kansas City
St. Mary's Health Center, Kansas City
Children's Mercy Hospital, Kansas City
Heartland Health System, St. Joseph
Cameron Community Hospital, Cameron
Bethany Medical Center, Mexico
St. Peters Hospital, St. Charles
Wentzville Hospital, Wentzville
Missouri Hospital Association
St. Mary's Hospital, Jefferson City
St. John's Hospital, Springfield

Physicians

Family practitioner, Mound City
Retired M.D., St. Louis
Pediatrician, St. Charles
Neonatologist, Springfield
(2) Family practitioners, Springfield
(2) Obstetricians, Springfield

Nurses

Missouri Nurses Association
(2) School Nurses

Home Health

Missouri Visiting Nurses Association
Home health agency

Local Governments/Public Health Depts.

Kansas City Dept. of Health
Prenatal Clinic, Buchanan County Public Health Dept.
Buchanan County Public Administrator
Greene County Public Health Dept.
Mid-America Regional Council

State Agencies and Representatives

Dept. of Mental Health
Division of Medical Services/Dept. of Social Services
Division of Family Services/Dept. of Social Services
Dept. of Health
Division of Insurance/Dept. of Economic Development
State representative

Social Service/Social Service Advocacy

Missouri Association for Social Welfare
Mid-America Assistance Coalition
Gray Panthers
Women's Equity Action League
Family Planning Services
Head Injury Foundation
Buchanan County Welfare Board
Communicating for Agriculture, Inc.
Lutheran Family and Children's Services
Diabetes Association
Missouri Protection and Advocacy Services
Salvation Army
People's Coalition of Missouri
Springfield Council of Churches
American Association of Retired Persons
Reform Organization of Welfare
Medicaid Alliance

Consumers

7 consumers had problems in paying for pregnancy care
6 consumers had problems concerning coverage of or after catastrophic illness
2 consumers were Medicaid recipients
4 consumers had no insurance coverage following unemployment

Businesses or Business Coalitions

Mid-America Coalition on Health
St. Louis Area Business/Health Coalition
General American Life Insurance Company
McDonnell Douglas

Labor Groups

AFL-CIO United Way Service, St. Joseph

SUMMARY OF TESTIMONY

The committee held many hours of hearings. All of the suggestions made cannot be expressed here. The following information provides an overview of some of the opinions expressed to the committee.

Hospitals

* Changing governmental and private insurance reimbursement systems are exacerbating the indigent care problem.

* Medicaid reimbursements are often inadequate to cover the costs of treatment.

* Prenatal care and preventative care are cost-efficient.

* Increased uncompensated care will force some hospitals to limit indigent care in order to remain fiscally solvent.

* Hospitals' indigent care burdens have increased significantly in recent years.

* Governmental regulations have increased the cost of hospital care.

* Many rural hospitals are in danger of closing.

* Patients are delaying needed treatment because of inability to pay.

* Public and children's hospitals are bearing a disproportionate share of the indigent care burden because of their missions and clientele.

Physicians

* Economic conditions in rural areas are seriously affecting patient's willingness to seek needed care and their ability to pay for it.

* Physician recruitment and retention is difficult in depressed rural areas.

* Increasing costs of liability insurance are adversely affecting physicians' ability to provide charity care.

* Prenatal care is cost-efficient.

* The liability exposure of physicians for indigent care should be reduced.

* The state should set up programs to reduce the cost of caring for "walk-in" obstetrical patients, especially in Springfield.

Nurses

* School nurses are seeing increasing needs for adequate health care in children of families who cannot afford care for all their members.

* Nurses should be specifically included into a MedAssist program, as they are cost-effective health care providers.

* Preventative health care should be emphasized.

* The expanded role of nursing should be used to improve access to health care.

Home Health

* Home health care is cost-effective and should be specifically encouraged in state medical assistance programs for the indigent.

Local Governments/Public Health Departments

* Reimbursements for health care through capitated state programs are increasingly inadequate.

* A state indigent care program would improve the availability of needed preventative and primary care.

* Physicians providing services in public health clinics should have less paperwork and less liability exposure.

* Local governments are adversely affected by rural economic problems and have limited ability to address increased indigent care problems.

* The establishment of a medical residency program in Springfield would improve care there.

State Agencies and Representatives

* A study of indigent health care in Missouri by Health Systems Research, Inc. found that 20% of the state's population has substandard health insurance coverage.

* The state's institutionalized mental health patients usually have no health insurance coverage and, if not covered by Medicaid, their care is usually paid solely by the state.

* Insurance coverage for mental health would benefit the state.

* A state grant proposal to a private foundation may improve access to indigent care services.

* Preventative care should be emphasized by the state.

* In addressing the indigent care problem, the state should avoid a premium tax or mandated benefits.

* In developing a MedAssist program, procedures should be coordinated with the Medicaid program to maximize federal funding.

* The Medicaid program is designed only to provide care for certain categories of recipients, not for all those below income guidelines.

* A medically needy program should be enacted as part of Medicaid.

* Counties need the authority to levy taxes for indigent care.

* A referendum election for the MedAssist program would be costly; funding from sales tax is regressive and should be avoided.

Social Service Advocacy

* The Medicaid program does not provide acceptable health care because of poor reimbursements for services and cost-containment policies which restrict access to the most effective care.

* Eligibility limits for Medicaid are too low to provide coverage for those who need health care and cannot afford it.

* High-risk insurance pools are effective means of ensuring access to coverage.

* Even modest deductibles and copayment rates will deter impoverished patients from getting care.

* Primary health care should be encouraged.

* Sales tax should be exempted from insulin and diabetic syringes.

* The state should have an open formulary for pharmaceuticals.

* The disabled and handicapped have difficulty getting insurance.

* Health programs should concentrate on patients' most essential needs and should emphasize preventative care.

* The state should ensure that insurance "continuation and conversion" policies are available.

* Family planning programs are cost-effective.

* Long-term care should be part of the coverage of a MedAssist program.

* MedAssist benefits should not be better than Medicaid benefits.

* Current income maintenance policies are a disincentive to work.

* Psychiatric illnesses should be covered on a par with physical ailments.

Consumers

* The costs of a catastrophic illness can cripple a family of moderate income with normal insurance coverage.

* Respite care is needed for the families of patients with catastrophic illnesses.

* Insurance for high-risk patients is unaffordable or unavailable.

* Freedom of choice among physicians should be part of governmental health programs.

* Medicaid limits on certain services adversely affect health.

* Patients who cannot afford care forego needed services.

* Patients who cannot afford care are generally willing to pay reasonable amounts for insurance coverage.

* Minimum wage workers cannot afford insurance if it is not offered as a fringe benefit of employment.

* Temporary unemployment causes temporary but risky medical indigence.

Business or Business Coalitions

* The benefit plan of a MedAssist program should be designed so as not to exceed available revenues.

* Competition in the health care system should be encouraged.

* A MedAssist program should be enacted for several years rather than permanently to allow for program review.

* Indigent patients should be expected to pay for a portion of their care.

* The Medicaid program should not be expanded.

* A MedAssist program should be based on actuarial principles.

* An indigent care program should use utilization review, avoid mandated benefits, distribute costs fairly, and maximize federal funding.

* Health care providers should stop cost-shifting if a state program is implemented.

Labor Groups

* The poor agricultural economy is harming patients' ability to pay for and willingness to receive needed care.

* The economy is increasingly emphasizing jobs which are low-paying and do not have insurance benefits.

* Increased sales tax should not be used to fund a MedAssist program, for it is regressive. The income tax should be used instead.

* The MedAssist program should benefit rural as well as urban areas.

APPENDIX B: Text of HCS/SCR No. 6

Dick

HOUSE COMMITTEE SUBSTITUTE

FOR

SENATE CONCURRENT RESOLUTION NO. 6

WHEREAS, the Missouri General Assembly is genuinely concerned about the quality and availability of health services for financially and medically needy persons in this state; and

WHEREAS, it appears that a significant number of citizens of the state may not be receiving adequate health services because of their particular financial and/or health needs; and

WHEREAS, various cities, counties and agencies of the state provide certain health services for those needy persons; and

WHEREAS, there is a need to study the effectiveness of the various health programs and the delivery of health services; and

WHEREAS, there is a need to study the coordination and interrelationships of the various health programs and services offered or provided by the federal government, the state government and various local governments so as to provide the best health care possible from the resources which are available:

NOW, THEREFORE, BE IT RESOLVED by the Senate, the House of Representatives concurring therein, that a joint committee of the Missouri General Assembly be created to be composed of five members of the Senate and five advisory, nonvoting members of the general public appointed by the president pro tem, and five members of the House and five advisory, nonvoting members of the general public appointed by the speaker, and the following advisory, nonvoting members: the director of the Department of Social Services or his designee, the director of the Department of Health or his designee, the director of the Department of Mental Health or his designee, the Commissioner of Administration or his designee, the Commissioner of Education of the Department of Elementary and Secondary Education or his designee and the director of the Department of Labor and Industrial Relations or

his designee; and

BE IT FURTHER RESOLVED that the committee be directed to make a thorough study of the system of health services in Missouri for the financially and medically needy which shall include, but shall not be limited to the following:

(1) Better coordination of existing state health care programs;

(2) The structure of the existing health services system;

(3) The provision and availability of health services across the state;

(4) The level of funding of health services and how funding is directed;

(5) The state's use of federally funded health services;

(6) Incentives and disincentives for providers to participate in current health programs providing care to the financially and medically needy; and

BE IT FURTHER RESOLVED that the staffs of the Committee on Legislative Research, the Senate Research office and the House Research office provide such legal, research, clerical and bill drafting services as the committee may require in the performance of its duties; and

BE IT FURTHER RESOLVED that the committee be authorized to function during the interim period between the First and Second Regular Sessions of the Eighty-fourth General Assembly; that actual and necessary expenses of the committee and its members, incurred in the attendance of meetings of the committee or any subcommittee thereof, be paid from the joint contingent fund and that the expenses of the department representatives and staff members assigned to the committee be paid from their respective funds; and

BE IT FURTHER RESOLVED that the committee prepare a report, together with recommendations for any legislation it deems appropriate, for submission to the Second Regular Session of the Eighty-fourth General Assembly.